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ABSTRACT

Although the children in Texas face health and welfare issues common to other states, such as changing family structures, poverty, expanding immigrant populations, and tight budgets, there are unique aspects to Texas that must be factored in. These include having 254 counties, the largest rural population of any state, and a 46 percent increase in the number of children living in poverty since 1980. These factors create problems for both education and health care delivery. This report presents a demographic profile of Texas' children and the state in which they live out their lives. It relates demographic trends to issues that are vital to the future of Texas' children so that accurate and timely planning of strategies can be developed. There are three major sections to the report. The first presents data on Texas children and families, focusing on the factors that cause children to be at risk, as well as those demographic aspects of the state that have to do with the quality of life for Texas' children. The second section deals with the specific education and health risks among Texas' children, and the third section presents some ideas as to how education and health practitioners can work together, particularly through early prevention and intervention efforts. Model programs are presented that demonstrate how to improve the lives of children and their families while saving money for the state. (TJQ)

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Texas' *YOUTH*, Texas' *FUTURE*

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The National Health/Education Consortium

Recognizing the need for better integration of health and education services for children, the National Commission to Prevent Infant Mortality and the Institute for Educational Leadership organized the NATIONAL HEALTH/EDUCATION CONSORTIUM (NHEC) in 1990. The project has brought together leaders from 57 national health and education organizations, representing nearly 12 million constituents to bridge the separate worlds of health and education into more unified action for children. Promoting the full potential of children and providing them with the best opportunities for success will require changes in the systems which currently provide health and education services.

Toward this end, NHEC's activities focus on three major goals: to improve public policy in addressing the need for a better coordinated health and education delivery system; to strengthen communication and dissemination of information between health and education programs and policymakers; and to act as a catalyst for collaborative action at the national, state, and local levels.

Major funding for the NHEC is provided by the Prudential Foundation. Additional grants have been received from the Honeywell, Metropolitan Life, and AT&T Foundations, and the Procter & Gamble Fund, as well as the U.S. Department of Health and Human Services and the U.S. Department of Education.

The Institute for Educational Leadership

The Institute for Educational Leadership (IEL), a 29 year-old not-for-profit organization based in Washington, D.C., seeks to improve policies and systems that educate and support children and families by developing and supporting leaders who work together. IEL's activities engage education and health/human service agencies, schools, school boards, advocacy groups, foundations, corporations, and all levels of government. IEL's Center for Demographic Policy provides critical data and analysis to help policy makers ask the right questions and arrive at solutions that reflect our country's changing demography. Through a national publications program, IEL disseminates information about emerging trends and issues identified by research and demographic analysis.

The National Commission to Prevent Infant Mortality

The National Commission to Prevent Infant Mortality was established by Congress in 1987 to create a national strategic plan to reduce infant mortality and morbidity in the United States. The sixteen-member Commission includes Members of Congress, the Secretary of Health and Human Service, the Comptroller General of the United States, representatives of state government, and experts in the field of maternal and child health. Knowing that many, if not most, of the answers to promoting the health of mothers and children have existed for decades, the Commission focuses on practical solutions at the federal, state, and local levels for improving the health and well-being of mothers and children. Current efforts focus on bringing national attention and a strengthened momentum to activities which promote the health and well-being of mothers, infants, and children.

PS

Texas' *YOUTH*, Texas' *FUTURE*

a report prepared for the
National Health/Education Consortium

by
Harold L. Hodgkinson
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December 1993

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Janice Hamilton Outtz, the Co-Director of IEL's Center for Demographic Policy, was instrumental in leading the data collection efforts as well as editing the report. She was also responsible for production of the report. Janice was ably assisted by Anita M. Obarakpor, Research Associate at the Center. At the Institute for Educational Leadership, I would like to extend my sincere appreciation to Michael Usdan, the President, for his guidance, support, and editorial assistance. Louise Clarke, also at the Institute, was very helpful, as usual, in getting this report to press.

The opinions expressed in this report do not necessarily reflect the views or the positions of the AT & T Foundation, the National Health/Education Consortium, or the Institute for Educational Leadership.

Harold L. Hodgkinson

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Preface

December 1993

Dear Friends:

Texas' children, like too many children in states all across the country, face a host of risks to their health and well-being. They confront overwhelming social, economic, housing, health, and education problems. Minority children and those living in poverty are disproportionately affected by many of these risks.

Demographic trends tell us where the needs are greatest. The information in this report gives us all ample reason to continue to place the children of Texas in a position of high priority, recognition and action.

We need to focus on children's needs starting before they are born. Pregnant women need quality prenatal care, young children need comprehensive well child care and high quality comprehensive early childhood programs, school-age children need a growing array of preventive support services, and our teenagers need increasingly more assistance and guidance from programs available to them. We must reach out to children and families in need, not just for their sake but for all of us. When our children and families are strong, our states can be strong.

The National Health/Education Consortium hopes that by highlighting the demographic trends concerning children and families in Texas, the citizens of this state will be more motivated than ever to take appropriate action on behalf of these vulnerable citizens who most need our assistance. We welcome your thoughts on this report and, more importantly, your involvement to make the health and well-being of the children of Texas and of other states a top priority today and in the future.

Sincerely,

Lawton Chiles
Co-Chair, National Health/Education Consortium
and Chairman, NCPIM

William Woodside
Co-Chair, National Health/Education Consortium
and Chairman, IEL

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Texas' *YOUTH*
Texas' *FUTURE*

Introduction

This report presents a demographic snapshot of Texas' children and the state in which they live out their lives. While the children in Texas face issues common to other states (changing family structures, growing poverty among families with young children, expanding immigrant populations and very tight budgets) there are certain unique aspects to Texas that must be factored in. These unique aspects include things such as having 254 counties to California's 58, having the largest rural population of any state (3.3 million) and a 46 percent increase (one of the highest in the nation) in the number of children with incomes below the poverty line since 1980, (most of whom were in single parent-households). These factors create problems for both education and health care delivery.

Although the relationship between education and health care is obvious (it is virtually impossible to teach sick children), the two bureaucracies operate in splendid isolation in most states. Texas is unusual in that a number of programs have begun that enable both educators and health care professionals to work together for the benefit of children.

This report attempts to relate demographic trends to issues that are vital to the future of Texas' children so that accurate and timely planning of strategies can be developed. This report is one of a series of publications from the National Health/Education Consortium (NHEC), an organization of over 57 national groups which have come together to promote better coordination between the worlds of health and education.

There are three major sections to this report. The first presents data on Texas children and families, focusing on the factors that cause children to be at risk, as well as those demographic aspects of the state that have to do with the quality of life of Texas' children. The second section deals with the specific education and health risks among Texas' children while the third section presents some ideas as to how education and health practitioners can work together, particularly through

early prevention and intervention efforts. Finally, model programs are presented which demonstrate how to improve the lives of children and their families while saving money for the state.

Texas' Children and Their Families

Children

According to the 1990 census, there were 4,835,352 children (population under age 18) in Texas, 12.3 percent more than in 1980. The state's total population of 16,986,510, the third largest in the nation, expanded by 19.4 percent in the last decade. This smaller increase in children as compared to the total population, indicates that young people, while a growing segment of the overall population, did not keep pace with the growth in the rest of the state. (People over 65, for example, expanded at 24.6 percent, double the rate for children, and creating concern for how many voters will be supportive of children's issues.) By the time the next census is taken, the growth rate in Texas will give the state an estimated 20,210,000 people, propelling it past New York to claim the ranking of second largest state in the nation. (Unless otherwise noted, all data are from *The Nation and the States*. See references for complete citation.)

Table 1
Texas' Children by Race and Ethnicity, 1990
(in thousands)

	Number	Percent Change, 1980-90
Total, Under Age 18	4,835	up 12.3
Non-Hispanic White	2,487	up 2.1
African American	639	up 7.1
Asian	94	up 143.4
Hispanic*	1,598	up 30.6
Native American	18	up 50.1

*Persons of Hispanic origin may be of any race.
Source: Population Reference Bureau, *The Challenge of Change*, 1992.

Racial and Ethnic Diversity

While the number of children in Texas increased 12.3 percent, there were some striking differences by race and ethnic background (see Table 1, above). The fastest growing group of children in Texas between 1980 and 1990 were Asian Americans.

Forty-nine percent of Texas' youth were minority in 1990 when the census was taken. Nearly 57 percent are projected for 2010, raising the question of how we can call this group "minority" if they number more than half? In 2010, New York, California, Texas and Florida will have one third of the nation's children, and all four will have a "minority majority" among youth.

Child Poverty

There were 1,159,710 children in Texas below the poverty line in 1990, an increase of 46 percent from 1980. This was one of the fastest increases in the nation among states. Racial and ethnic poverty rates vary considerably (see Table 2). While nearly three million Texans (15.9 percent of the total population) were poor in 1990, 24 percent of Texas' children were poor, or one child in four.

There are also major differences in income levels by family type in Texas. We have seen that children in single-parent households are much more likely to be poor than children in married-couple households. According to the Population Reference Bureau, seventy-one percent of Texas' children lived in married-couple families in 1990, while 16.7 percent of Texas' poor children live in married-couple families (see Table 3, next page).

A child raised by its mother alone will have an available income of one-third the income available to a child in a married-couple family, if raised by the father the income will be a little over half. Single mothers, raising only 15 percent of Texas' children, are raising more than half of the poor children in Texas, according to the Population Reference Bureau. Because the number of single-parent households is increasing so rapidly, it is clear that Texas can count on a steady increase in the number of children in poverty. (It is also very unclear how a state recoups after an increase of 46 percent in the number of poor youth in a decade!)

Several other factors are important in the Texas situation, the first being rural poverty. Texas' children living in rural areas live in a vast area in which health, education and other services needed can be fifty or more miles away. Many of these children live in counties that are too poor to provide services. Because rural poverty is so low in density, it does not make vivid pictures on the evening news. But in many ways it is more difficult to deal with than urban poverty.

Rural schools are particularly hard pressed. According to the Austin Center for Educational Research, in 1900, there were 11,460 school districts in the state, 2,748 in 1950 and

Table 2
Texas' Children in Poverty by Race and Ethnicity, 1990

	Number	Percent of Total[1]
Total[2]	1,159,710	24.3
White	612,724	18.3
African American	254,287	39.3
Hispanic[3]	638,905	40.2
Asian American	14,518	15.6
Native American	4,501	25.6

[1]Poor children as a percent of all children by race/ethnicity.
[2]Includes other races, not shown separately.
[3]Persons of Hispanic origin may be of any race.
Source: Population Reference Bureau, *The Challenge of Change*, 1992.

Table 3
Texas' Children
by Family Type and Income, 1990

	Total Number of Children	Percent	Average Household Income ($)	Number of Children in Poverty	Percent of Children who are Poor
Married couple families with children	3,448,126	71.3	43,790	611,802	16.7
Female headed families with children	741,097	15.3	15,800	473,054	52.3
Male headed families with children	144,123	3.0	25,439	55,511	31.2
Other*	486,162	10.1	---	---	---

*Includes children raised by grandparents (a rapidly increasing number), raised by non-relatives, foster care, etc.
Source: Population Reference Bureau, *The Challenge of Change*, 1992.

1,058 in 1989. But in 1989, 413 school districts had fewer than 500 students in grades K-12, while 8 urban districts had over 50,000. There is a limit to school consolidation in a state like Texas. Some children are just spread too thin to allow for high quality education/health services to be easily available. In addition, border counties in Texas have to deal with large numbers of children of illegal immigrants and many other difficult issues.

Language is also an issue, in that English is not the major language spoken at home for 28 percent of Texas youth age 5 to 17 years. For nearly 26 percent of the youth, the major language spoken at home is Spanish.

Of the 1.5 million immigrants admitted to the U.S. in 1990, only three states got 67 percent of the national total: California, 682,979, New York, 189,589 and Texas, 174,132, according to the Immigration and Naturalization Service. The Texas immigrant population is overwhelmingly Hispanic, from Mexico and some from Central America. The language/immigration issues often blend, particularly on the question of whether to provide education and health care to the children of illegal immigrants.

Children At Risk

First, it needs to be pointed out that to be at risk is **not** to be doomed to failure. Any number of young people who come from the worst environments can eventually make major contributions to American life. But they are working "against the grain," and the odds against them can

be great. One way to think about the issue of children at risk in Texas would be to compare the state on some specific indicators.

The Annie E. Casey Foundation published a book of such indicators in 1993. The indicators in the *Kids Count Data Book*, included: infant mortality, births to teenage mothers, high school dropout rates, juvenile crime and incarceration rates, percentage of children raised by single parents, etc. Texas ranked 31st overall among the states in the 1993, having ranked 33rd in 1992. However, the crucial index of children in poverty remains unchanged. Texas ranked 43rd among the states - 42 states have a smaller percentage of children in poverty than Texas. Texas, California and Florida captured half the **nation's** growth 1980-1990, which translated into huge growth in new jobs and increases in Gross State Product, but not in the condition of life for their children. All three states rank in the lower half on the Casey measures.

Risk levels are strikingly different by county in Texas, and the best data source for this is *The State of Texas Children, 1993*. Besides concurring with us that poverty is the underlying cause of risks to children, *The State of Texas Children* points out that:

- Child poverty increased in 223 counties in Texas; by 100 percent in 14 counties.
- Seventeen counties have a higher rate of child poverty than Detroit.
- Seventy percent of the people receiving AFDC aid in Texas are children; 56 percent of Food Stamp recipients are children and 53 percent of individuals covered under Medicaid are youngsters.
- Forty percent of Texas Hispanic children live in poverty; 39 percent of black children.
- Texas ranks 48th in early prenatal care for pregnant mothers. (A dollar spent on prenatal care saves three dollars in neonatal intensive care costs alone.)
- Only 10 percent of Houston children are adequately immunized by their second birthday.
- Texas serves only 34 percent of the women and children eligible for WIC benefits (a federal food and nutrition program), although every dollar Texas invests in WIC saves $2.44 in the state's Medicaid costs.
- Forty-six percent of all Texas school children depend on the National School Lunch program during the school year; only 10 percent get this nutritional supplement during the summer.
- In FY 1992, there were 39,674 confirmed cases of child abuse and neglect in Texas, involving 100,995 children.
- Texas spends an average of $40,000 a year to keep a youth in a juvenile detention center; $3,877 on a student in public school. The $40,000 would allow six Texas

young people to go to college for a year.

This list is not presented as a diatribe, but as a single point: Texas does not invest adequately in prevention programs for its youth, and thus the taxpayer pays at least four times more for child protection, mental health and criminal justice interventions than a good prevention program would cost. You can pay now or pay later. The **most** costly social service in Texas is jails and prisons - 57,000 prisoners, the second highest number in the nation (although Texas ranks 12th in violent crime), and each prisoner costs the state $15,000 a year just to maintain. That is close to one billion dollars a year. Texas is also adding 38,800 new prison beds at an additional cost of $1.1 billion, according to the Corrections Compendium.

A person in poverty has a good chance of getting out of poverty in three to four years with a little help. A prisoner serving a 20 year, non-commutable sentence **cannot** get out early, and will cost the state $300,000 over the life of the sentence. (When he/she does get out, they will more likely be back in jail within three years in more than 60 percent of the time). This is in part a prevention issue. The juvenile violent crime arrest rate in Texas went from 195 per 100,000 youths in 1986 to 347 in 1991. By keeping more young people in school until graduation, most would have a reasonable chance to support themselves in the workplace without turning to crime.

Minorities in Texas' Suburbs

In Houston, 145,000 black citizens live in the suburbs, along with 242,000 Hispanics. In Dallas, one can find 95,000 black and 127,000 Hispanic suburban residents. In addition, San Antonio, McAllen-Mission, Brownsville, El Paso and Corpus Christi, all have suburban Hispanic populations which total over 50,000, according to *American Demographics* magazine (1993). Most of these developments occurred during the 1980s, creating a large pool of middle-income, property-owning, tax paying, well-educated minority households. But even suburban Hispanics in Texas have far lower incomes than California and Florida suburban Hispanics, although the cost of living is usually lower in Texas as well. Texas has always had more rich, more poor, and fewer in the middle than the nation as a whole, and this is still true as the number of minority children in poverty are increasing much faster than the number of minority suburban children. And the fact that Texas has the largest population of rural children in poverty in the nation constitutes a special problem for education and health care.

Health Risks

There are several dimensions in which Texas children are very much at risk in terms of their health. The most important (and oftentimes cheapest to fix) is the lack of prenatal care in the first trimester. In California, six percent of

the pregnant women received late or no care in 1990. In Florida, it was 8.2 percent, in New York it was 6.9 percent and in Texas it was 11.5 percent, almost twice the California rate. In addition, *The State of Texas Children*, reports that the percentage of pregnant women receiving early prenatal care has actually declined. Much of this is a rural issue, as mothers in Texas' rural areas must drive long distances to get to what may be inadequate services. Federal programs are available such as WIC and Medicaid to assure that pregnant women get early diagnosis, comprehensive services and good nutrition during pregnancy, but these programs are serving about one-third of those eligible. (For medicaid, a state contribution is required.) We have already seen that in Texas, one dollar spent in prenatal care will save Texas three dollars in neonatal intensive care costs alone, an excellent return for the taxpayer's investment!

A second health risk occurs immediately after birth with childhood diseases that can be prevented through vaccination. Only 30 percent of Texas' children are immunized by age two, and among at-risk children the rate is even lower, according to *The State of Texas Children*. (By school age, 95 to 98 percent of Texas' children are immunized, but many diseases won't wait until then.) So while 98 percent of Texas two year old cattle are fully immunized in Texas, according to the U.S. Department of Agriculture, only 30 percent of Texas' two-year old children are. It would be hard to make the case that Texas can find the resources to vaccinate cattle but that children are less deserving of the same service. President Clinton's administration is taking steps to reduce the current average $200 fee for comprehensive vaccinations, but there is no serious reason for Texas to wait. A child who develops polio will cost the state many thousands of times the cost of the vaccine, leaving the ethical issues aside.

A third major risk factor is in births to teenage mothers in Texas. In 1991, over 50,000 babies were born to mothers who were themselves children, a rate of 28 babies born per 1,000 teen-age girls. Children born to young mothers are much more likely to grow up in unstable families, and will usually perpetuate the cycle in their own children.

When a rural teenager gives birth, it is even less likely that mother and baby will begin their life together in a healthy, secure environment with essential services easily available. Once again, the long term cost to the Texas taxpayer of ignoring this issue will be enormous, over the life of a mother and child. This issue is linked to education, as a teen mother who does not finish high school is very likely to be reliant upon state sponsored health and welfare services for many years as will her child.

Texas currently has the highest percentage of people without health insurance in the nation at 26 percent, or about 4 million citizens. But among children in Texas, 40 percent have no health insurance, according to the Texas Research League.

The State's Response

Several encouraging actions have taken place during Governor Richards' term in office beginning in 1990. A high priority was meeting the needs of the uninsured Texas population, especially for young children and pregnant mothers without health insurance. In 1992, the state expanded its Medicaid program to offer coverage to pregnant women and children with family income up to 185 percent of the Federal poverty line. In addition, funding for the state's Early, Periodic Screening, Diagnosis and Treatment (EPSDT) program was tripled from $83 million to $258 million. Additional proposals sought to increase the state's Medicaid-based budget for services to pregnant women and children from $2.4 billion to $6.6 billion, resulting in health coverage for an additional 4 million children and 200,000 pregnant women. The state would pay only $1.5 billion of the increase, the rest being covered by federal matching funds. However, it is not clear at this writing where the state's contribution would come from. It seems likely that further state initiatives will await the definitive Clinton health package as modified by the Congress. However, several new ventures are now in operation. The Texas Caring Program for Children provides insurance coverage for all basic health services including outpatient surgery and emergency care at a very low cost. (Administrative costs are covered by Texas Blue Cross and Blue Shield.) Money is raised for the program through 26 major league baseball players who generate contributions to the program by hitting home runs. The program is currently providing funds for about 221 children and will soon expand to 1,500.

The Texas Maternal and Child Health Coalition, an association of over 40 statewide organizations, has been active since 1985 in supporting increased access to health care for mothers and children in Texas. They hope in 1993 to work toward a "seamless" delivery system for health care as well as establishing their Smart Start program.

Education Risks

One of the major future problems facing Texas is the need to build the 37,000 additional classrooms needed by 1996, as the school-age population increases by 1.1 million, according to Texas Research League. Related is the issue of the state's disparity in spending per student, ranging from $14,514 in wealthy districts to $2,150 in poor districts, actually larger than the Kentucky disparity in rich and poor districts. There has been no definitive court action in Texas similar to that in Kentucky, which declared the Kentucky schools illegal because of uneven spending per student.

The problems of Texas school districts covering a large number of square miles and a very small number of students (and tax dollars) cannot be solved through additional consolidation alone. Texas also has one of the highest dropout rates in the nation. Nearly thirteen percent of children age 16 to 19 drop out of school each year, totalling a decline of 33 percent in each

class over the high school years. In addition, large numbers of youth leave school **before** age 16, resulting in even higher numbers of dropouts. Less than 65 percent of all youth currently graduate from high school in Texas. One of the problems is the large number of Texas children who have to repeat a grade, as this doubles their chances of dropping out, as the Texas Research League has pointed out in their excellent report *Putting the Pieces Together.*

Another complex of educational issues involves children who do not speak English, and who come from families in which the adults are not well educated themselves. For example, in Texas 72 percent of adult whites have completed high school, but only 43 percent of Hispanic adults, and 68 percent of the black adults have, according to the Texas Research League. At the college level, 20 percent of white adults have a degree, but only 11 percent of black adults and 7 percent for Hispanics.

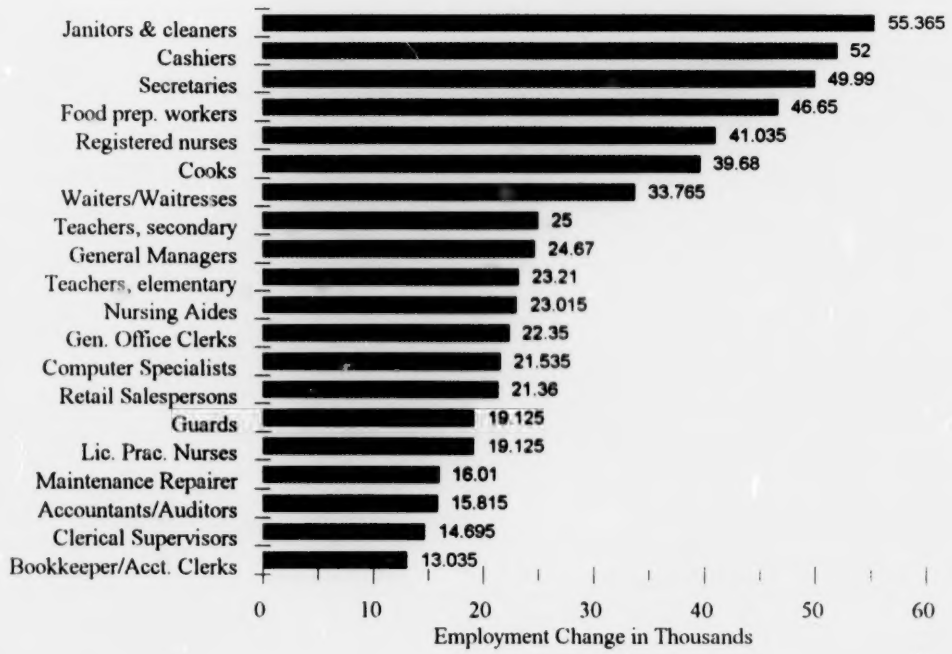
Many recent immigrants to Texas do not speak English well. Dropouts can be predicted by: (1) a high proportion of illiterate adults (in English); and (2) a high proportion of disadvantaged minorities. Texas is among the highest in the nation on both counts.

The State's Response

One of the most successful programs in Texas and the nation is Eugene Lang's I HAVE A DREAM, which basically provides college tuition for underprivileged children who would otherwise have no incentive to stay in school or to do well. The program in Dallas has already adopted more than 2,000 students with excellent results in terms of staying in school and doing well academically. (This program, initiated through private foundations, has now been adopted by a number of state legislatures.)

The school to work transition can be assisted by apprenticeships, co-op programs and "tech-prep" programs which combine the last two years in high school with two years of postsecondary education and/or apprenticeships. The San Antonio Educational Partnership puts together these and other motivators to encourage young people to stay in school and graduate, then to move on to college or a job. These "compact" programs represent agreements between schools, colleges and businesses that greatly increase motivation to graduate from high school, as one of two happy results, a job or access to college, is a normal expectation. A major Texas problem is the kind of jobs that are being added to the economy. Between 1980 and 1990, the largest number of new jobs were in occupations that did not require much in the way of educational credentials at all: janitors and cleaners, cashiers, secretaries and food prep. workers led the list (see Figure 1, next page). The 20 occupations listed in figure 1 represent one in three jobs in Texas, suggesting that there are indeed two work forces developing in Texas, one a high skilled work force of college graduates with technical and professional skills, and a second work force of high school dropouts performing low pay, low skill work for minimum wage. In terms of **new** jobs

Figure 1
Occupations Adding the Most Jobs in Texas
1980 to 1990



Source: Texas Employment Commission

added to the Texas economy, the second work force will be larger than the first. All states are pondering how to develop more high skill, high wage jobs to replace manufacturing jobs lost, but there are few good answers. In the nation, about 11 new jobs were created for janitors for every new job for a computer programmer.

A vital educational issue deals with whether or not jobs will exist for the various education and training programs, given the numbers we have presented. However, the school-to-work transition is the key factor behind apprenticeships, tech-prep, and compacts, programs actively sponsored by Texas businesses.

Early childhood programs are a vital link to education improvement, and businesses have been assisting through the Margaret H. Cone Center in Dallas, Project CARE in El Paso. Other programs deal with older students who are behind or have dropped out, such as San Angelo's P.A.Y.S. school (Preparing Area Youth for Success), Richland Restart,

the PAL Program (Peer Assistance and Leadership) which is now offered in over 200 Texas school districts. Although Texas currently is moving much more rapidly to meet educational needs of at-risk students, baseline measures, such as dropout rates and passage rates of state competency tests such as TEAMS/TASS, teen pregnancy rates, violent deaths among teens, and above all children in poverty, have shown little change. Texas was ahead of most states by passing legislation to define factors producing school dropouts as early as 1987, but the crucial indicators have not yet improved. Texas is spending an enormous amount of money in trying to repair the damage to young people after the fact, rather than preventing the damage in the first place.

Linking Education and Health Care In Texas

Texas has long been active in the area of linking education and health care services, through several strategies:

- The **Comprehensive School Health Program** is a joint effort of the Texas Department of Health, the Texas Education Agency, the Board of Nurse Examiners and the Texas Cancer Council. Through cooperative funding, the state has established twenty regional education service centers for assisting schools and school districts build more effective programs. In addition, the program makes possible direct health services through registered nurses throughout the state.

- The **"Essential Elements of Instruction"** provided by the Texas State Board of Education includes instructional goals that stress the physical, mental, emotional and social dimensions of health, and develop health knowledge and good health practices in students.

- **Drug use prevention** is a vital part of the effort to coordinate health and education, as is HIV education, the Pregnancy, Education and Parenting Program as well as the Nutrition Education Program. These efforts all link the development of good health knowledge and practice with the Texas instructional program.

- A **Texas Comprehensive School Health Initiative** (is a coalition of 30 health and education agencies and associations that support the programs listed above through conferences and awards for exemplary programs. Since 1992, through the leadership of Governor Ann Richards, TCSHI has housed and coordinated the work of the Texas State Health/Education consortium, one of NHEC's three state-level health/education consortia.

- In the Texas Education Agency, a series of curriculum documents called **Education for Self-Responsibility** provide an integrated approach to health education. All four were completed in 1992-93, and are currently used as models by the U.S. Department of Education, which has recognized

more Drug-Free schools in Texas than in any other state.

There is a strategy in these activities that is unusual, in that in addition to the provision of health services in school settings (it is where the children are), the Texas curriculum mandates that Texas students must acquire specific knowledge of their own health needs, and practice health care in their own lives. Similarly, teachers must know health principles and practices, as well as drug prevention knowledge and behavior, as part of their professional knowledge base as teachers. In this way, Texas has formed a lasting linkage between education and health care by changing the school curriculum *and* professional standards for teachers, in addition to the provision of direct health care by registered nurses in schools throughout the state.

Conclusion

By 1996, Texas will have 1.1 million more public school students than at present. In addition to building 37,000 new classrooms, these children represent a rapidly increasing number and percentage who are in poverty, who do not speak English at home, who are being raised by single parents at low income levels, who lack adequate nutrition and health care and who are very likely to drop out of school. (Texas has one of the highest rates of dropouts in the nation.) Just to "stay even" in terms of quality of life for its youth, Texas will have to make a major effort.

Because of its vast differences in density and wealth, the issue of equity (giving each young person the opportunity to fulfill their potential regardless of circumstances of birth) is a particularly vexing one in Texas. The problem of rural youth poverty adds considerably to the complexity of the state's task, as do linguistic and ethnic diversity. The commendable efforts thus far to increase the percentage of Texans with health insurance, especially pregnant women and children, as well as to provide preventive services, plus the school-based programs that provide health education as well as health services, will not be enough to allow the state to "break even" in terms of youth quality of life in the future.

County, city and state governments as well as businesses and community leaders will have to develop common goals and strategies for achieving them, a form of collaboration not always used to solve Texas problems! However, the problems of Texas' young people are too visible and urgent to be ignored. There is no choice but to take these issues very seriously. They do represent, after all, the future of the state.

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National Health/Education Consortium Members

- **American Academy of Family Physicians**: represents 71,000 physicians
- **American Academy of Pediatrics**: represents 45,000 pediatricians
- **American Association of Colleges for Teacher Education**: represents 706 member institutions' teacher education programs
- **American Association of School Administrators**: represents 18,517 school administrators
- **American College of Nurse-Midwives**: represents 3,500 practicing nurse-midwives
- **American College of Obstetricians and Gynecologists**: represents 31,000 obstetricians and gynecologists
- **American Dental Association**: represents 140,000 dentists
- **American Federation of Teachers**: represents 750,000 teachers, para-professionals (teacher aides), school-related personnel, health-care workers, federal and state employees
- **American Hospital Association (MCH Section)**: represents 5,870 hospitals and over 50,000 physicians
- **American Indian Health Care Association**: represents 36 programs and clinics which focus on the health care of American Indians
- **American Medical Association**: represents 300,000 physicians
- **American Nurses Association**: represents 201,000 registered nurses
- **American Public Health Association**: represents 30,977 physicians, nurses, therapists, health technicians, health support personnel, and other health professionals
- **American School Food Service Association**: represents 65,000 child nutrition and school food service employees
- **American School Health Association**: represents 4,100 health educators, nurses, physicians and dieticians
- **American Speech-Language-Hearing Association**: represents 74,000 speech-language pathologists, audiologists, scientists, researchers and educators
- **Association for the Care of Children's Health**: represents 4,200 nurses, Child Life workers, and parent leaders
- **Association for Supervision and Curriculum Development**: represents 153,000 teachers, school administrators, college professors and school board members
- **Association for Women's Health, Obstetric and Neonatal Nurses**: represents 24,700 nurses
- **Association of American Medical Colleges**: represents 126 U.S. medical schools, 450 teaching hospitals, and 94 academic professional societies
- **Association of Maternal and Child Health Programs**: represents 269 maternal and child health program directors and staff
- **Association of Schools of Public Health**: represents 14,500 faculty and students at 26 certified schools of public health

- ❑ **Association of State and Territorial Dental Directors**: represents 44 state dental directors nationwide
- ❑ **Association of State and Territorial Health Officials**: represents 58 health officers from each of the United States and its territories
- ❑ **Council of Chief State School Officers**: represents 56 public officials who head departments of elementary and secondary education in each state and extra-state jurisdiction
- ❑ **The Council of Great City Schools**: represents 47 of the largest urban public school districts in the United States
- ❑ **Healthy Mothers, Healthy Babies Coalition**: represents 95 non-profit health education groups, and state and local education groups
- ❑ **National Alliance of Black School Educators**: represents 4,000 African-American teachers for grades K-12
- ❑ **National Association for Asian & Pacific American Education**: represents approximately 500 educators concerned for the educational well-being of Asian and Pacific American students
- ❑ **National Association for Partners in Education**: represents 55,000 volunteers, presidents and executives of private businesses, teachers and administrators
- ❑ **National Association for the Education of Young Children**: represents nearly 77,000 professionals and others who study or are interested in childhood education and development
- ❑ **National Association of Children's Hospitals and Related Institutions**: represents 108 hospitals
- ❑ **National Association of Community Health Centers**: represents 600 health care facilities
- ❑ **National Association of Elementary School Principals**: represents 36,000 elementary school principals, middle school principals, school superintendents, teachers, professors and instructors
- ❑ **National Association of Hispanic Nurses**: represents 1,000 Hispanic nurses
- ❑ **National Association of Pediatric Nurse Associates and Practitioners**: represents 4,200 pediatric nurse associates and practitioners
- ❑ **National Association of School Nurses, Inc.**: represents 8,000 school nurses
- ❑ **National Association of Secondary School Principals**: represents 41,000 secondary school principals, administrators, guidance counselors, activities directors and college professors
- ❑ **National Association of Social Workers, Inc.**: represents 145,000 professionals and para-professionals in the field of social work
- ❑ **National Association of State Boards of Education**: represents 600 state boards of education and their members
- ❑ **National Association of WIC Directors**: represents 624 state directors, nutrition coordinators, and local agency directors
- ❑ **National Black Nurses Association**: represents 7,000 African-American nurses
- ❑ **National Coalition of Hispanic Health and Human Services Organizations (COSSMHO)**: represents 12,000 organizations serving the Hispanic population, representing Hispanic physicians, nurses and students

- **National Community Education Association**: represents 1,600 teachers, superintendents, administrators, community education directors and coordinators, faculty and administrators of teacher education institutions and programs, community activists, private businesses and state administrators
- **The National Congress of Parents and Teachers (PTA)**: represents 6.8 million parents, K-12 classroom teachers, principals, school administrators and students
- **National Education Association**: represents 2 .1 million K-12 class room teachers, professors, educational support personnel and students
- **National Elementary School Center**: represents 500 educators, pediatricians, social workers, school administrators, and parents
- **National Head Start Association**: represents 150 nationwide agency members and 30 individual members
- **National Indian Education Association**: represents 2,700 individuals dedicated to promoting quality education for American Indian and Alaskan Native people
- **National Medical Association**: represents 16,500 primarily African-American minority physicians
- **National Mental Health Association**: represents 550 local affiliate mental health associations, comprised of mental health care providers and clients, and community mental health centers
- **National Perinatal Association**: represents 6,000 physicians, nurses, nurse-midwives, social workers and consumers of perinatal services
- **National Rural Health Association**: represents 2,000 community, migrant and homeless health centers and their staffs
- **National School Boards Association**: represents 52 state school board associations
- **National School Public Relations Association**: represents 2,200 teachers, principals, administrators, retired teachers, students and public relations personnel
- **Society for Neuroscience**: represents 21,219 neuroscientists
- **Zero to Three (National Center for Clinical Infant Programs)**: Represents 7,500 programs for high risk children and families, as well as individuals

NHEC Parent Organizations

National Commission to Prevent Infant Mortality

The National Commission to Prevent Infant Mortality (NCPIM) was formed by Congress in 1987 to create a national plan to reduce infant mortality and morbidity in the United States. The sixteen-member Commission, chaired by Governor Lawton Chiles (FL), includes Members of Congress, the Secretary of Health and Human Services, the Comptroller General of the United States, representatives of state government, and experts in the field of maternal and child health.

Knowing that many, if not most, of the answers to how to promote the health of mothers and children have existed for decades, the Commission choses to focus on practical solutions at the federal, state and local levels for improving the health and well-being of mothers and children rather than create a new body of research.

The Institute for Educational Leadership

The Institute for Educational Leadership (IEL), whose programs date back to 1964, was initiated as an Institute of the George Washington University and became an independent, non-profit organization in 1981. The Institute for Educational Leadership's stock-in-trade is ongoing leadership programs operating in Washington, D.C. and more than 40 states. These programs help decision-makers to understand and more effectively address significant educational policy issues.

The Institute for Educational Leadership, while anchored in the field of education, has broadened its activities to other policy and service arenas which affect schools with increasing frequency and importance. Because it does not have a single membership base, IEL is particularly well positioned to use its convening capacities to serve as a broker and bridge between schools and the myriad societal agencies and forces with which education is inextricably linked. IEL is chaired by William S. Woodside, Chairman, Sky Chefs Inc.